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A STUDY ON HEALTH STATUS AND HEALTH SEEKING BEHAVIOUR OF RURAL WOMEN IN COIMBATORE

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ABSTRACT

Objectives: To determine the health status and health seeking behavior of rural women.

The researcher considered only the households, which had children below 5 years of age as sample and the same was confirmed by going through the Civil Registration Report. It has been adopted to analyze the maternity and child health practices.

Materials and methods: Thus in total, 300 respondents are selected as sample from Coimbatore.

Results: A study of data in the health status and health seeking behaviour of the rural women respondents. It could be noted that out of the total 300 respondents, 16.67 per cent of them belong to the forward caste and 24.00 per cent of them belong to Backward Caste. In this study, the Most Backward Caste constitutes 41.33 per cent of the respondents and 18.00 per cent of them constitute Scheduled Caste.

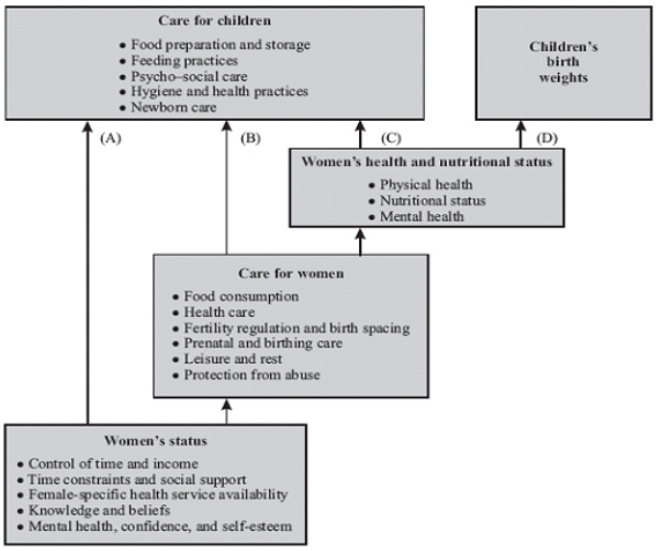
INTRODUCTION

Women's health in India has assumed importance only of late, particularly after the International Conference on Population and Development held at Cairo, Egypt in September 1994 and the fourth World Conference on Women, held in Beijing in September 1995. Both these conferences placed immense importance on women's health, empowerment and reproductive rights. Not discounting the importance of health needs and health status of men, the fact remains that over a lifetime the health of women is usually worse than that of men. Moreover, certain health problems are more prevalent among women than among men and certain health problems are unique to women and affect women differently when compared with men. Furthermore, some environmental problems have a disproportionate impact on women compared to their male counterparts.

The Links between Women's Status and Child Nutritional Status

In this section the relationship between women's status and child nutritional status are discussed with special emphasis on care for children and children's birth weights. The reader should keep in mind that in many countries women play a major role in maintaining household food security (Quisumbing et al. 1995) and household health environments (Hoddinott 1997) The influence of status on the ability of women to fulfill their roles in these areas is not addressed in this study due to lack of data. It remains an important area for future research. Figure 1 delineates the major pathways through which women's status influences care for children and children's birth weights. Five caring practices for children are crucial for their nutritional well-being: food preparation and storage, feeding practices, psychosocial care, hygiene and home health practices (Engle, Menon, and Haddad 1999) and newborn care. Foods entering the household must be stored in a hygienic manner and prepared in special ways so that children can eat them. Appropriate food must be offered to the child with correct timing and frequency. The child must receive adequate psychosocial care, including affection and warmth, responsiveness, and the encouragement of autonomy and exploration. The child's environment must be clean to protect him or her from disease.

Figure Women's status, care for children d children's birth weights



Source: Adapted from Engle, Menon, and Haddad (1999)

Review of Literature

Generally, the term woman is used to refer to a female of at least fifteen years of age. But, health of a woman, thus defined, is intertwined with her health related experiences in the early years of life. According to the National Population Policy, 2000, "The complex socio-cultural determinants of women's health and nutrition have cumulative effects over a lifetime. Discriminatory childcare leads to malnutrition and impaired physical development of the girl child". It is also said that nutrition in early adolescence is crucial to woman's well being and through her, to the well being of children. Also in India, "social, cultural and economic factors continue to inhibit women from gaining adequate access to even the existing [italics added] public health facilities. This handicap does not just affect women as individuals; it also has an adverse impact on the health, general well-being and development of the entire family, particularly children". This statement shows the inherent nature of the society which stands in the way of women getting adequate health care, the inadequacy of the available health care facilities and the importance of women's health

in deciding the health of other members of the family, particularly children.

Provision of health in the Indian families generally is along the lines of sex, age, status and role in the family and women generally come at the end of the line. But India is a large country which harbors a thoroughly heterogeneous group of people in terms of religion, caste, language, ways of living, economic status, or levels of education. All these separate groups and their sub-groups have their own cultural values and norms which will have an impact on their attitude to life in general and health care in particular. Nevertheless, it is felt that women's position is more or less the same across the board with only degrees of differences.

India is one of the few countries on the planet Earth, where women and men have nearly the same life expectancy at birth. The lack of typical female advantage in life expectancy in India suggests that they are inherent particularly during childhood and in their reproductive years. The health of Indian women is intrinsically linked to their status in society. The contributions Indian women used to make to families are often overlooked in so many cases, and instead they are taken as economic burdens. There is a strong preference for sons in India, as sons are expected to take care of their parents as they grow old. This son preference, along with high dowry costs for daughters, sometimes results in the mistreatment of daughters. Further, the majority of Indian women have low levels of both education and formal labor force participation. Some studies suggest that they typically have very limited autonomy, firstly living under the control of their fathers, then their husbands, and finally their sons (Chatterjee, 1990; Desai, 1994).

Research Objective

1. To determine the health status and health seeking behavior of rural women.

Research Methods and Data Analysis

ANOVAs tests are also used to examine the variation between the health status of the rural women. It is written as shown in the table below:

Table 1. ANOVA TEST

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Sum of Squares	Ratio of F
Between Samples	SSC	(c-1)	MSC = SSC/(c-1)	MSC/MSE
Between Rows	SSR	(r-1)	MSR = SSR/(r-1)	MSR/MSE
Residual or Error	SSE	(c-1) (r-1)	MSE = SSE/(r-1) (c-1)	
Total	SST	n-1		

SSC = Sum of squares between columns

SSR= Sum of squares between rows

SSE = Sum of squares due to error

SST = Total sum of squares

The sum of squares for the source 'Residual' was obtained by subtracting from the total sum of squares the sum of squares between columns and rows, i.e.,

SSE = SST – (SSC + SSR)

The total number of degrees of freedom = n –1 or cr-1

Where c refers to number of columns, and r refers to number of rows,

Number of degrees of freedom between columns = (c-1)

Number of degrees of freedom between rows = (r-1)

Number of degrees of freedom for residual = (c-1) (r-1)

The total sum of squares, sum of squares for between columns and sum of squares for between rows were obtained in the same way as before.

Residual or error sum of square = Total sum of squares – sum of squares between columns – sum of squares between rows.

The F values are calculated as follows:

$$F(V_1V_2) = \frac{MSC}{MSE}$$

Where,

$V_1 = (c-1)$ and $V_2 = (c-1)(r-1)$

$$F(V_1V_2) = \frac{MSR}{MSE}$$

Where,

$V_1 = (r-1)$ and $V_2 = (c-1)(r-1)$

It should be carefully noted that may not be same in both cases in one case $V_1 = (c-1)$ and another case $V_1 = (r-1)$

The calculated values of F are compared with the table values. If the calculated value of F is greater than the table value at pre-assigned level of significance, the null hypothesis is rejected; otherwise it is accepted.

Findings and Discussions

A study of data in table 1 indicates the socio economic status of the women respondents. It could be noted that out of the total 300 respondents, 16.67 per cent of them belong to the forward caste and 24.00 per cent of them belong to Backward Caste. In this study, the Most Backward Caste constitutes 41.33 per cent of the respondents and 18.00 per cent of them constitute Scheduled Caste. The Most Backward Caste and Backward Caste represent larger number of respondents than the other caste respondents. Out of the total 300 respondents, 13.67 per cent of them are illiterates, 23 per cent of them are educated upto the primary level, 30 per cent of them have secondary education, 18 per cent of them are undergraduates, and 15.33 per cent of the respondents are post-graduates. The discussion clearly envisages that nearly a two-thirds of the respondents have secondary and higher levels of education. In this study, illiterates are less than literates. Of the total 300 respondents, 28.53 per cent of them are housewives, 39.42 per cent of them are labourers, 17.95 per cent of them are private sector employees group and 14.1 per cent of them are government employees. Majority of the respondents are employees, especially, labourers and some of them are housewives.

Scope for Future Study and Conclusions

The present study has been conducted in coimbatore. A similar study could be conducted in other parts of the Tamil Nadu. There is a need to conduct research study on rural health promotional measures from the point of view of rural health mission. The impact of rural health mission on rural women health care behavior and child health care practices could be evaluated. The role of health workers in promotion of rural women health status could be assessed with a view to understand the effectiveness of rural health women schemes in India.

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